TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-17-2714-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 15, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount. After review the account we have concluded that reimbursement received was inaccurate."

Amount in Dispute: $198.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 17, 2017	72114,72131	$198.76	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 00223 – (P12) Workers' compensation jurisdictional fee schedule adjustment
  - 97 – The benefit for this service is included in the payment/allowance for another service/procedure

that has already been adjudicated
- MSIN – this is a packaged item. Services or procedures included in the APC rate, but NOT paid separately
- MOPS – Services reduced to the Outpatient Perspective Payment System (OPPS)
- W3 – Request for reconsideration
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. What is the applicable rule that pertains to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking $198.76 for outpatient hospital services with date of service January 17, 2017. The carrier reduced the payment amount as 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and P12 – "Workers compensation jurisdictional fee schedule adjustment."

   The requestor states in pertinent part, "…we have concluded that reimbursement received was inaccurate." The Respondent states in pertinent part, "…the carrier asserts that it has paid according to applicable fee guidelines..." Therefore, the service in dispute will be reviewed per applicable Rules and Fee Guidelines discussed below.

   The relevant portions of 28 Texas Administrative Code 134.403 are:

   (b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise

   (3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

   (f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

   (A) 200 percent; unless

   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent

The Medicare Claims processing Manual defines the terms, Status Indicators, APC Payment Groups and Composite APCS as follows:

- **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,

- *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

– **10.1.1 - Payment Status Indicators**

An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. For example, services with status indicator A are paid under a fee schedule or payment system other than the OPPS. Services with status indicator N are paid under the OPPS, but their payment is packaged into payment for a separately paid service. Services with status indicator T are paid separately under OPPS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.

The full list of status indicators and their definitions is published in Addendum D1 of the OPPS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPS Addendum B.

– **10.2 - APC Payment Groups**

Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. (See section 10.5 for discussion of multiple procedure discounting under the OPPS).

– **Composite** - *Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.*

Review of Addendum B – Final OPPS Payment by HCPCS Code found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html, for date of service January 17, 2017 finds;

- Procedure code 72114 has status indicator Q1, denoting STV-packaged codes; reimbursement is included in the package for any service with status indicator S, T or V — not separately paid unless no other such services are billed. Reimbursement for this service is included with payment for procedure code 72131 billed on the same claim. Separate payment is not recommended.

- Procedure code 72131 has status indicator Q3. This service is assigned to composite APC 5522. As the packaging criteria is not met, this service is eligible for separate payment under the status indictor of "S". The OPPS Addendum B rate is $112.73. This is multiplied by 60% for an unadjusted labor-related amount of $67.64, which is multiplied by the facility wage index of 0.8026 for an adjusted labor amount of $54.29. The non-labor related portion is 40% of the APC rate, or $45.09. The sum of the labor and non-labor portions is $99.38. The Medicare facility specific amount of $99.38, is multiplied by 200% for a MAR of $198.76.

2. The total recommended reimbursement for the disputed services is $198.76. The insurance carrier has paid $198.76 leaving an amount due to the requestor of $0.00. Additional payment is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		June 8, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.